Silver Full PPO 1700 OffEx

Benefit Summary (For groups 1 to 50)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2015

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This health plan uses the Full PPO provider network.

DEDUCTIBLE	Participating Providers[2]	Non-Participating Providers[2]
Calendar Year Medical Deductible (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year medical deductibles.)	$ 1,700 per individual/ $ 3,400 per family	$ 3,400 per individual / $ 6,800 per family
Calendar Year Brand Drug Deductible (Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum.**)**	$300 per individual / $600 per family	Not Covered
Calendar Year Out-of-Pocket Maximum[1] (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximums.)	$6,250 per individual/ $12,500 per family	$10,000 per individual / $20,000 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	Member Copayment	
PROFESSIONAL SERVICES	**Participating Providers[2]**	**Non-Participating Providers[2]**
Professional (Physician) Benefits		
Physician office visits	$40 per visit (not subject to the calendar year medical deductible)	50%
Specialist office visits	$50 per visit (not subject to the calendar year medical deductible)	50%
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine[3] (prior authorization is required)	30%	50%
Outpatient diagnostic X-ray and imaging[3] (non-hospital based or affiliated)	30%	50%
Outpatient diagnostic laboratory and pathology[3] (non-hospital based or affiliated)	30%	50%
Allergy Testing and Treatment Benefits		
Office visits (includes visits for allergy serum injections)	30%	50%
Preventive Health Benefits		
Preventive health services[4] (as required by applicable federal and California law)	No Charge[4] (not subject to the calendar year medical deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
Outpatient surgery performed at an ambulatory surgery center[5]	30%	50%[6]
Outpatient surgery in a hospital	30%	50%[6]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits")	30%	50%[6]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital[3] (prior authorization is required)	$100 per visit + 30%	50%[6]
Outpatient diagnostic X-ray and imaging performed in a hospital[3]	30%	50%[6]
Outpatient diagnostic laboratory and pathology performed in a hospital[3]	30%	50%[6]

Bariatric surgery[7] (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%[6]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	30%	50%
Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)	30%	50%[8]
Bariatric surgery[7] (prior authorization required; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%[8]
Skilled Nursing Facility Benefits[9, 10] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)		
Services from a free-standing skilled nursing facility	30%	30%
Skilled nursing unit of a hospital	30%	50%[8]
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$200 per visit + 30%	$200 per visit + 30%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	30%	30%
Emergency room physician services	30%	30%
Urgent care	$40 per visit (not subject to the calendar year medical deductible)	Not Covered
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	30%	30%
PRESCRIPTION DRUG COVERAGE[11, 12, 13, 14, 23]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[14]	No Charge (not subject to the calendar year medical deductible)	Not Covered
Generic drugs	$15 per prescription	Not Covered
Preferred brand drugs	$50 per prescription	Not Covered
Non-preferred brand drugs	$75 per prescription	Not Covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[14]	No Charge (not subject to the calendar year medical deductible)	Not Covered
Generic drugs	$30 per prescription	Not Covered
Preferred brand drugs	$100 per prescription	Not Covered
Non-preferred brand drugs	$150 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs[12]	30% per prescription	Not Covered
Oral anticancer medications	30% up to $200 maximum per prescription	Not Covered
PROSTHETICS/ORTHOTICS	**Participating Providers[2]**	**Non-Participating Providers[2]**
Prosthetic equipment and devices (separate office visit copayment may apply)	30%	Not Covered
Orthotic equipment and devices (separate office visit copayment may apply)	30%	Not Covered
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the calendar year medical deductible)	Not Covered
Other durable medical equipment	50%	Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES [18]	**MHSA Participating Providers[2]**	**MHSA Non-Participating Providers[2]**
Inpatient Hospital Services	30%	50%[8]
Residential Care	30%	50%[8]
Inpatient Physician Services	30%	50%

Routine Outpatient Mental Health and Substance Abuse Services (includes professional/physician visits)	$40 per visit (not subject to the calendar year medical deductible)	50%
Non-Routine Outpatient Mental Health and Substance Abuse Services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, and transcranial magnetic stimulation, For partial hospitalization programs, a higher copayment & facility charges may apply per episode of care)	30%	50%
HOME HEALTH SERVICES	**Participating Providers[2]**	**Non-Participating Providers[2]**
Home health care agency services[9] (up to 100 prior authorized visits per calendar year)	30%	Not Covered[15]
Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a home infusion agency	30%	Not Covered[15]
OTHER		
Hospice Program Benefits		
Routine home care	No Charge	Not Covered[15]
Inpatient respite care	No Charge	Not Covered[15]
24-hour continuous home care	No Charge	Not Covered[15]
Short-term inpatient care for pain and symptom management	No Charge	Not Covered[15]
Chiropractic Benefits		
Chiropractic services[1] (up to 12 visits per calendar year)	50% (not subject to the calendar year medical deductible)	50% (not subject to the calendar year medical deductible)
Acupuncture Benefits		
Acupuncture services	$25 per visit	50%
Rehabilitation/Habilitation Benefits		
Office location	30%	50%
Pregnancy and Maternity Care Benefits		
Prenatal and preconception physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services	No Charge (not subject to the calendar year medical deductible)	50%
Prenatal and preconception physician office visit: subsequent visits	30%	50%
Postnatal physician office visits (for inpatient hospital services, see "Hospitalization Services)	30%	50%
Abortion services	30%	50%
Family Planning Benefits[24]		
Counseling and consulting[4, 16]	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tubal ligation[4]	No Charge (not subject to the calendar year medical deductible)	Not Covered
Vasectomy[17]	30%	Not Covered
Diabetes Care Benefits		
Devices, equipment, and non-testing supplies (for testing supplies see outpatient prescription drug benefits.)	50%	Not Covered
Diabetes self-management training in an office setting	$40 per visit	50%
Care Outside of Plan Service Area (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the Participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

Optional Benefits

Optional dental, vision, and infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

Pediatric Dental Benefits to Age 19

Pediatric dental benefits are not reflected in this benefit summary. Please refer to the separate Pediatric Dental Benefit Summary for a summary of benefits.

Pediatric Vision Benefits to Age 19 (not subject to the calendar year medical deductible)

Comprehensive Eye Exam[19]: one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	No Charge	Up to $30 Maximum Allowance
Optometric - New patient exams (92002/92004) - Established patient exams (92012/92014)	No Charge	Up to $30 Maximum Allowance
Eyeglasses		
Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (Lined) bifocal (V2200-2299) - Conventional (Lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass, plastic, or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	No Charge	Covered up to a maximum allowance of: $25 single vision $35 lined bifocal $45 lined trifocal $45 lenticular
Optional Lenses and Treatments		
UV coating	No Charge	Not Covered
Anti-reflective coating	$35	Not Covered
High-index lenses	$30	Not Covered
Photochromic lenses - plastic	$25	Not Covered
Photochromic lenses - glass	$25	Not Covered
Polarized lenses	$45	Not Covered
Standard progressives	$55	Not Covered
Premium progressives	$95	Not Covered
Frame[20] (one frame per calendar year)		
Collection frames	No Charge	Up to $40 Maximum Allowance
Non-Collection frames	Up to $150 Maximum Allowance	Up to $40 Maximum Allowance
Contact Lenses[21]		
Non-Elective (Medically Necessary) – Hard or soft One pair per Calendar Year	No Charge	Up to $225 Maximum Allowance
Elective (Cosmetic/Convenience) – Standard hard (V2500, V2510) One pair per Calendar Year	No Charge	Up to $75 Maximum Allowance
Elective (Cosmetic/Convenience) – Non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531) One pair per Calendar Year	No Charge	Up to $75 Maximum Allowance
Elective (Cosmetic/Convenience) – Standard soft (V2520) One pair per month, up to 6 months, per Calendar Year	No Charge	Up to $75 Maximum Allowance
Elective (Cosmetic/Convenience) – Non-standard soft (V2521-V2523) One pair per month, up to 3 months, per Calendar Year	No Charge	Up to $75 Maximum Allowance
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[22]	30%	Not Covered
Diabetes management referral	No Charge	Not Covered

1 Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum except copayments or coinsurance for:

- Charges in excess of specified benefit maximums
- Bariatric surgery: covered travel expenses for bariatric surgery
- Chiropractic benefits
- Dialysis center benefits: dialysis services from a Non-Participating Provider

Copayments, coinsurance and charges for services not accruing to the member's calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment/coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum.

3 Participating non-hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities may not be available in all areas; however the member can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

5 Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefits.

6 The allowable amount for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-Participating hospital is $350 per day. Members are responsible for 50% of this $350 per day, plus all charges in excess of $350.

7 Bariatric surgery is covered when prior authorized by Blue Shield; however, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons. Coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Summary of Benefits and *Evidence of Coverage* for further details.

8 The allowable amount for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 50% of this $600 per day, plus all charges in excess of $600. Charges that exceed the allowable amount do not count toward the calendar year out-of-pocket maximum.

9 Services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the calendar year medical deductible has been met.

10 Services may require prior authorization. When services are prior authorized, a member's share-of-cost is paid at the participating provider amount.

11 If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar year medical or brand drug deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation.

12 Specialty Drugs are specific drugs used to treat complex or chronic conditions, which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the member or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy, and may require prior authorization by Blue Shield. Infused or Intravenous (IV) medications are not considered Specialty Drugs. Specialty Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.

13 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

14 Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment. However, if a brand contraceptive is requested when a generic equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. The difference in cost that the member must pay is not applied to the calendar year medical or brand drug deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. In addition, select contraceptives may need prior authorization to be covered without a copayment.

15 Services from non-participating providers, home health care, home infusion and hospice services are not covered unless prior authorized. When these services are prior authorized, a member's share-of-cost is paid at the participating provider amount.

16 Includes insertion of IUD as well as injectable contraceptives for women.

17 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Non-participating provider facilities are not covered under this benefit.

18 Mental health and substance abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating and non-participating providers. Only Mental Health and Susbtance Abuse services rendered by Blue Shield MHSA participating providers are administered by the Blue Shield MHSA. Mental health and Substance Abuse services rendered by non-participating providers are administered by Blue Shield. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Summary of Benefits and *Evidence of Coverage*. Inpatient services for acute medical detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers

19 The comprehensive examination benefit allowance does not include fitting and evaluation fees for contact lenses.

20 This Benefit covers Collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "Collection" but are required to maintain a comparable selection of frames that are covered in full. For non-Collection frames the allowable amount is up to $150; however, if (a) the Participating Provider uses wholesale pricing, then the wholesale allowable amount will be up to $99.06, or if (b) the Participating Provider uses warehouse pricing, then the warehouse allowable amount will be up to $103.64. Participating Providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this Benefit, the Member is responsible for the difference between the allowable amount and the provider's charge.

21 Contact lenses are covered in lieu of eyeglasses once per Calendar Year. See the Definitions section in the *Evidence of Coverage* for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

22 A report from the provider and prior authorization from the contracted VPA is required.

23 Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the EOC. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated.

24 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply

Plan designs may be modified to ensure compliance with state and federal requirements.

This plan is pending regulatory approval.